CSCT ARM Proposed Language Meeting
February 23, 2005

Committee Members Present: Doug Sullivan, Drew Uecker, Carol Ewen, Jim Parker, Bob Runkel, Duane Preshinger, Michelle Gillespie, and Sara Loewen.

Interested Parties in attendance: Dan Carlson-Thompson, GTCMHC; Joan Hays, WMMHC; Michelle Hill, GTCMHC; Marlene Mowery, GTCMHC; Jeff Folsom, AWARE; Mike Kelly, AWARE; Kathleen Handley, AWARE; Julie Fink, QAD; Theresa Cardiello, AWARE; Sheryl Stassi-Lampman, AWARE; Dave Bennetts, Altacare

Michelle introduced the committee members and described how we got to the proposed rule language changes. Bob gave a few more details about how the CSCT program was re-established. He also described the certification of match process.

Carol commented that we went from a bundled daily rate to a fee for service rate with set limits. Bob described the reasons why we had to stop doing the bundled rate and went to the fee for service with a cap. Medical services provided by and billed through schools can't be "for profit". Rates are set to just cover the costs of the services provided.

It was decided to go over the proposed language changes one section at a time.

Section 1
Michelle described the changes to the written program. Diane White will still need to get Beal's (QAD) approval to drop the written program description requirement.
Comments
- *Happy to see "community" stressed in the description of the program.*

Section 2
Comments
- *"Coordinating with school personnel" was missing.*
- *Crisis intervention services relates to the Mental Health Centers.*
- *May need to add sub section c – "limited circumstances…" to limit outside services.*

    - *Section 6 may cover these outside services, and how to manage the special circumstances that a child may require these extra outside services.*
    - *Would need to clarify the meaning of "substantial".*
    - *Some services may need to be Prior Authorized by Diane White or First Health.*
    - *CSCT can not bill on same day that a child receives outpatient services. PA may be a way around this.*
    - *Capped rates vs. hours may solve one problem. Being able to spend the extra hours on one child, but may have to "borrow" from other children.*
    - *There can be no duplicate billing on the same day.*
        - *The chart of duplicative services is available to clarify these services*
- *There needs to be some avenue for requesting outside special services for high needs kids. Some way to support a high needs kid in the community.*
    - *KMA's (Kids Management Authority) concentrate on high needs kids. They are able to put together a treatment plan for the child which might call for CSCT services. This would be community level coordination.*
        - *KMA's are still in the developmental phase in most areas.*
- *Mental Health established the practice of not billing for same services on the same day.*
    - *An analogy of a broken arm was given. You can see an orthopedic surgeon and a PT on the same day for the same broken arm.*

Section 3

Comments

- *Thought 18 hours of training was pretty steep.*
    - *Staff in residential training only have to have 10 hours of training yearly.*
    - *This was set to correspond to continuing education requirements for school staff.*
    - *May need to add "and the application of these practices in a school setting" at the end of the sentence.*
    - *Move 3(c) to section 3(b), so it is under the behavior specialist position.*
        - *This training should be requirement of all staff to that everyone is on the same page.*
    - *From the licensing bureau's viewpoint, it is easier to monitor as it is written. Adding the extra statement adds too much flexibility.*
- *Is the signature of an "in-training" practitioner OK on the treatment plan. The supervisor should also sign off on the treatment plan written by the in-training practitioner.*

    - *The in-training practitioner's signature, and their supervisor's is recognized by the Mental Health division as sufficient on the treatment plan.*
- *In sub section (e) change school to "program".*
- *Why do you have to have 2 dedicated FTE for CSCT program. Are they still able to do outpatient services to meet MHC productivity requirements?*
    - *CSCT program requires dedicated staff during the school year. However, staff does not have to be exclusive to the CSCT program during non-school days.*
- *Carol suggested lowering the monthly billable units to 600. This would increase the rate, so you would still get the same amount of revenue, and yet get more flexibility in the program. Reducing the units to 600 may make the "comprehensive" part more feasible and gives flexibility to the program.*
    - *There was general discussion about this idea.*
    - *It was decided that we may be asking for too much too fast if we try to drop the units to 600. CMS may view this as too close to a "bundled rate". When the initial average of units per child was determined, it came out to about 60 units. If we cut the units to 600, we have no support in implementing this figure.*
    - *There was a question in (f) about the comparison data and baseline measurements. We don't want to include the current "buzz words" into the rule language.*

Section 4

Comments

- *Asked to clarify 4(iii) and 4(iv) "proportionate amount of billing units".*
    - *This was included to make sure that a ½ time summer program only bills for ½ of the monthly units (360). The billable units are proportionate to the staffing FTE for the summer program.*
        - *This will have to monitored "in good faith" by the MHC. It is not feasible to change the payment system for three months of the year to decrease units billed in summer months.*
- *It was suggested that we change 4(iii) to read "Maximum billing units must be reduced proportionately to the staffing level for a full-time program."*
- *There was general discussion of what a summer program should look like and how to incorporate the community involvement.*

Section 5

Comments

- *Glad to see the requirement of a self-assessment included.*

Section 6

Comments

- *This section was discussed along with Section 2.*
- *This gives the Department the final authority to determine if a child is receiving too much outpatient therapy along with CSCT services.*

Overall, the comments supported the proposed language changes to the ARM. The audience thanked the committee members for their work and thought they had done a great job clarifying and defining the CSCT program.

Bob and Michelle thanked everyone for their input. The next step will be the final committee review of the ARM. It will then be sent to the legal department. It will then go through the formal review process. It should be ready to implement on September 1, 2005 for the new school year.

The committee will meet on Tuesday, March 8th from 1-4pm in Cogswell room 205.